

By: Bonnen of Galveston

H.B. No. 2760

A BILL TO BE ENTITLED

AN ACT

relating to health benefit plan provider networks; providing an administrative penalty.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 842.261, Insurance Code, is amended by adding Subsections (a-1) and (a-2) and amending Subsection (c) to read as follows:

(a-1) The listing required by Subsection (a) must meet the requirements of a provider directory under Sections 1451.504 and 1451.505. The group hospital service corporation is subject to the requirements of Sections 1451.504 and 1451.505, including the time limits for directory corrections and updates, with respect to the listing.

(a-2) Notwithstanding Subsection (b), a group hospital service corporation shall update the listing required by Subsection (a) at least once every business day.

(c) The commissioner may adopt rules as necessary to implement this section. The rules may govern the form and content of the information required to be provided under this section [~~Subsection (a)~~].

SECTION 2. Section 843.2015, Insurance Code, is amended by adding Subsections (a-1) and (a-2) and amending Subsection (c) to read as follows:

(a-1) The listing required by Subsection (a) must meet the

1 requirements of a provider directory under Sections 1451.504 and
2 1451.505. The health maintenance organization is subject to the
3 requirements of Sections 1451.504 and 1451.505, including the time
4 limits for directory corrections and updates, with respect to the
5 listing.

6 (a-2) Notwithstanding Subsection (b), the health
7 maintenance organization shall update the listing required by
8 Subsection (a) at least once every business day.

9 (c) The commissioner may adopt rules as necessary to
10 implement this section. The rules may govern the form and content
11 of the information required to be provided under this section
12 ~~[Subsection (a)]~~.

13 SECTION 3. Section 1301.0056(a), Insurance Code, is amended
14 to read as follows:

15 (a) The commissioner shall ~~[may]~~ examine an insurer to
16 determine the quality and adequacy of a network used by a preferred
17 provider benefit plan or an exclusive provider benefit plan offered
18 by the insurer under this chapter. An insurer is subject to a
19 qualifying examination of the insurer's preferred provider benefit
20 plans and exclusive provider benefit plans and subsequent quality
21 of care and network adequacy examinations by the commissioner at
22 least once every two ~~[five]~~ years. Documentation provided to the
23 commissioner during an examination conducted under this section is
24 confidential and is not subject to disclosure as public information
25 under Chapter 552, Government Code.

26 SECTION 4. Section 1301.1591, Insurance Code, is amended by
27 adding Subsections (a-1) and (a-2) and amending Subsection (c) to

1 read as follows:

2 (a-1) The listing required by Subsection (a) must meet the
3 requirements of a provider directory under Sections 1451.504 and
4 1451.505. The insurer is subject to the requirements of Sections
5 1451.504 and 1451.505, including the time limits for directory
6 corrections and updates, with respect to the listing.

7 (a-2) Notwithstanding Subsection (b), an insurer shall
8 update the listing required by Subsection (a) at least once every
9 business day.

10 (c) The commissioner may adopt rules as necessary to
11 implement this section. The rules may govern the form and content
12 of the information required to be provided under this section
13 [~~Subsection (a)~~].

14 SECTION 5. Section 1451.504(b), Insurance Code, is amended
15 to read as follows:

16 (b) The directory must include the name, specialty, if any,
17 street address, and telephone number of each physician and health
18 care provider described by Subsection (a) and indicate whether the
19 physician or provider is accepting new patients.

20 SECTION 6. The heading to Section 1451.505, Insurance Code,
21 is amended to read as follows:

22 Sec. 1451.505. ACCESSIBILITY AND ACCURACY OF PHYSICIAN AND
23 HEALTH CARE PROVIDER DIRECTORY [~~ON INTERNET WEBSITE~~].

24 SECTION 7. Section 1451.505, Insurance Code, is amended by
25 amending Subsections (c), (d), and (e) and adding Subsections
26 (d-1), (d-2), (d-3), and (f) through (p) to read as follows:

27 (c) The directory must be:

(1) electronically searchable by physician or health care provider name, specialty, if any, and location; and

(2) publicly accessible without necessity of providing a password, a user name, or personally identifiable information.

(d) The health benefit plan issuer shall conduct an ongoing review of the directory and correct or update the information as necessary. Except as provided by Subsections (d-1), (d-2), (d-3), and (f) [Subsection (e)], corrections and updates, if any, must be made not less than once every business day ~~[each month]~~.

(d-1) Except as provided by Subsection (d-2), the health benefit plan issuer shall update the directory to:

(1) list a physician or health care provider not later than two business days after the effective date of the physician's or health care provider's contract with the health benefit plan issuer; or

(2) remove a physician or health care provider not later than two business days after the effective date of the termination of the physician's or health care provider's contract with the health benefit plan issuer.

(d-2) Except as provided by Subsection (d-3), if the termination of the physician's or health care provider's contract with the health benefit plan issuer was not at the request of the physician or health care provider and the health benefit plan issuer is subject to Section 843.308 or 1301.160, the health benefit plan issuer shall remove the physician or health care provider from the directory not later than two business days after

1 the later of:

2 (1) the date of a formal recommendation under Section
3 843.306 or 1301.057, as applicable; or

4 (2) the effective date of the termination.

5 (d-3) If the termination was related to imminent harm, the
6 health benefit plan issuer shall remove the physician or health
7 care provider from the directory in the time provided by Subsection
8 (d-1)(2).

9 (e) The health benefit plan issuer shall conspicuously
10 display in at least 10-point boldfaced font in the directory
11 required by Section 1451.504 a notice that an individual may report
12 an inaccuracy in the directory to the health benefit plan issuer or
13 the department. The health benefit plan issuer shall include in the
14 notice:

15 (1) an e-mail address and a toll-free telephone number
16 to which any individual may report any inaccuracy in the directory
17 to the health benefit plan issuer; and

18 (2) an e-mail address and Internet website address or
19 link for the appropriate complaint division of the department.

20 (f) Notwithstanding any other law, if [~~if~~] the health
21 benefit plan issuer receives an oral or written [~~a~~] report from any
22 person that specifically identified directory information may be
23 inaccurate, the issuer shall:

24 (1) immediately:

25 (A) inform the individual of the individual's
26 right to report inaccurate directory information to the department;
27 and

1 (B) provide the individual with an e-mail address
2 and Internet website address or link for the appropriate complaint
3 division of the department;

4 (2) investigate the report and correct the
5 information, as necessary, not later than:

6 (A) the second business ~~[seventh]~~ day after the
7 date the report is received if the report concerns the health
8 benefit plan issuer's representation of the network participation
9 status of the physician or health care provider; or

10 (B) the fifth day after the date the report is
11 received if the report concerns any other type of information in the
12 directory; and

13 (3) promptly enter the report in the log required
14 under Subsection (h).

15 (g) A health benefit plan issuer that receives an oral
16 report that specifically identified directory information may be
17 inaccurate may not require the individual making the oral report to
18 file a written report to trigger the time limits and requirements of
19 this section.

20 (h) The health benefit plan issuer shall create and maintain
21 for inspection by the department a log that records all reports
22 received under this section or otherwise regarding inaccurate
23 network directories or listings. The log required under this
24 subsection must include supporting information as required by the
25 commissioner by rule, including:

26 (1) the name of the person, if known, who reported the
27 inaccuracy and whether the person is an insured, enrollee,

1 physician, health care provider, or other individual;

2 (2) the alleged inaccuracy that was reported;

3 (3) the date of the report;

4 (4) steps taken by the health benefit plan issuer to
5 investigate the report, including the date each of the steps was
6 taken;

7 (5) the findings of the investigation of the report;

8 (6) a copy of the health benefit plan issuer's
9 correction or update, if any, made to the network directory as a
10 result of the investigation, including the date of the correction
11 or update;

12 (7) proof that the health benefit plan issuer made the
13 disclosure required by Subsection (f)(1); and

14 (8) the total number of reports received each month
15 for each network offered by the health benefit plan issuer.

16 (i) A health benefit plan issuer shall submit the log
17 required by Subsection (h) at least once annually on a date
18 specified by the commissioner by rule and as otherwise required by
19 Subsection (l).

20 (j) A health benefit plan issuer shall retain the log for
21 three years after the last entry date unless the commissioner by
22 rule requires a longer retention period.

23 (k) The following elements of a log provided to the
24 department under this section are confidential and are not subject
25 to disclosure as public information under Chapter 552, Government
26 Code:

27 (1) personally identifiable information or medical

1 information about the individual making the report; and

2 (2) personally identifiable information about a
3 physician or health care provider.

4 (1) If, in any 30-day period, the health benefit plan issuer
5 receives three or more reports that allege the health benefit plan
6 issuer's directory inaccurately represents a physician's or a
7 health care provider's network participation status and that are
8 confirmed by the health benefit plan issuer's investigation, the
9 health benefit plan issuer shall immediately report that occurrence
10 to the commissioner and provide to the department a copy of the log
11 required by Subsection (h).

12 (m) The department shall review a log submitted by a health
13 benefit plan issuer under Subsection (i) or (l). If the department
14 determines that the health benefit plan issuer appears to have
15 engaged in a pattern of maintaining an inaccurate network
16 directory, the commissioner shall investigate the health benefit
17 plan issuer's compliance with Subsections (d-1) and (d-2).

18 (n) A health benefit plan issuer investigated under this
19 section shall pay the cost of the investigation in an amount
20 determined by the commissioner.

21 (o) The department shall collect an assessment in an amount
22 determined by the commissioner from the health benefit plan issuer
23 at the time of the investigation to cover all expenses attributable
24 directly to the investigation, including the salaries and expenses
25 of department employees and all reasonable expenses of the
26 department necessary for the administration of this section. The
27 department shall deposit an assessment collected under this section

1 to the credit of the Texas Department of Insurance operating
2 account.

3 (p) Money deposited under this section shall be used to pay
4 the salaries and expenses of investigators and all other expenses
5 related to the investigation of a health benefit plan issuer under
6 this section.

7 SECTION 8. The heading to Chapter 1467, Insurance Code, is
8 amended to read as follows:

9 CHAPTER 1467. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION; NETWORK
10 ADEQUACY

11 SECTION 9. The heading to Subchapter D, Chapter 1467,
12 Insurance Code, is amended to read as follows:

13 SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION; NETWORK ADEQUACY

14 SECTION 10. Subchapter D, Chapter 1467, Insurance Code, is
15 amended by adding Sections 1467.152 and 1467.153 to read as
16 follows:

17 Sec. 1467.152. NETWORK ADEQUACY EXAMINATIONS AND FEES. (a)
18 At the beginning of each calendar year, the department shall review
19 mediation request information collected by the department for the
20 preceding calendar year to identify the two insurers with the
21 highest total number of mediation requests under this chapter for
22 the reviewed year.

23 (b) Not later than May 1 of each year, the department shall
24 examine any insurer identified under Subsection (a) to determine
25 the quality and adequacy of networks offered by the insurer.

26 (c) Documentation provided to the commissioner during an
27 examination conducted under this section is confidential and is not

1 subject to disclosure as public information under Chapter [552](#),
2 Government Code.

3 (d) An insurer examined under this section shall pay the
4 cost of the examination in an amount determined by the
5 commissioner.

6 (e) The department shall collect an assessment in an amount
7 determined by the commissioner from the insurer at the time of the
8 examination to cover all expenses attributable directly to the
9 examination, including the salaries and expenses of department
10 employees and all reasonable expenses of the department necessary
11 for the administration of this section. The department shall
12 deposit an assessment collected under this section to the credit of
13 the Texas Department of Insurance operating account.

14 (f) Money deposited under this section shall be used to pay
15 the salaries and expenses of examiners and all other expenses
16 related to the examination of an insurer under this section.

17 (g) An examination conducted by the department under this
18 section is in addition to any examination of an insurer required by
19 other law, including Section [1301.0056](#).

20 (h) The commissioner shall publish and make available on the
21 department's Internet website for at least 10 years after the date
22 of the examination information regarding an examination under this
23 section, including:

24 (1) the name of an insurer and health benefit plan
25 whose networks were examined under this section; and

26 (2) the year in which the insurer had the highest or
27 second highest total number of mediation requests under this

1 chapter.

2 Sec. 1467.153. TERMINATION WITHOUT CAUSE. (a) In this
3 section, "termination without cause" means the termination of the
4 provider network or preferred provider contract between a
5 physician, practitioner, health care provider, or facility and an
6 insurer for a reason other than:

7 (1) at the request of the physician, practitioner,
8 health care provider, or facility; or

9 (2) fraud or a material breach of contract.

10 (b) An insurer shall notify the department on the 15th day
11 of each month of the total number of terminations without cause made
12 by the insurer during the preceding month with respect to a health
13 benefit plan that is subject to this chapter. The notification
14 shall include information identifying:

15 (1) the type and number of physicians, practitioners,
16 health care providers, or facilities that were terminated;

17 (2) the location of the physician, practitioner,
18 health care provider, or facility that was terminated; and

19 (3) each health benefit plan offered by the insurer
20 that is affected by the termination.

21 (c) The department may investigate any insurer notifying
22 the department of a significant number of terminations without
23 cause with respect to a health benefit plan subject to this chapter.
24 The investigation must emphasize terminations without cause that:

25 (1) may impact the quality or adequacy of a health
26 benefit plan's network; or

27 (2) occur within the first three months after an open

1 enrollment period closes.

2 (d) Except for good cause shown, the department shall impose
3 an administrative penalty on an insurer if the department makes a
4 determination that the terminations without cause made by an
5 insurer caused, wholly or partly, an inadequate network to be used
6 by a health benefit plan that is offered by the insurer. The
7 department may not grant a waiver from any related network adequacy
8 requirements to an insurer offering a health benefit plan with an
9 inadequate network caused, wholly or partly, by terminations
10 without cause made by the insurer.

11 (e) Personally identifiable information regarding a
12 physician or practitioner included in documentation provided to or
13 collected by the department under this section is confidential and
14 is not subject to disclosure as public information under Chapter
15 552, Government Code.

16 SECTION 11. This Act takes effect September 1, 2017.